Practitioner/Clinic Name: _____

Contact Information: _____

Screening Questionnaire

Client Information

Client Name: _____ Date: _____

Preferred phone number: _____ Best time to call: _____

Email address:_____ Preferred form of communication: _____

Massage Information

How did you hear about me? (referral, Facebook, etc.) _____

Is this a gift certificate? Yes ☐ No ☐

Massage history:

Have you had a massage/bodywork before? Yes ☐ No ☐

Frequency: _____

Types of massage/bodywork received: _____

Preferred types of massage: _____

Reasons for seeking massage? (relaxation, injury, etc.)

_____

Description of injury/health condition:

_____

Possible complications/medications:

_____

Expected outcomes (functional improvement, symptom relief, wellness):

_____

Typical activities of daily living (affected by condition?):

_____

Occupation (affected by condition?):

_____

Are you seeking insurance reimbursement? Yes ☐ No ☐

Car collision/personal injury? _____

On-the-job injury? _____

Private health insurance? _____

Do you have a physician referral with diagnosis codes? _____

Let clients know if you provide billing services, and if so, for what types of claims, or if you will simply provide receipts and/or copies of records for them to submit for reimbursement. Let clients know a physician referral demonstrating medical necessity is required for insurance reimbursement/health savings account reimbursement regardless of who submits bills.

Best times for massage: _____

Practitioner/Clinic Name: _____

Contact Information: _____

Screening Questionnaire

Communication Checklist

Fees/forms of payment	Cancellation/No-show policy
Late arrival policy	Confidentiality
Parking/directions	Work setting
Clothing/shiatsu	Modesty/Nonsexual/draping
Food/drugs/alcohol	Oils/lotions/allergies

COVID-19 Related Questions

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ☐ No ☐
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ☐ No ☐
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

Inform clients of any new protocols you've implemented as a result of COVID-19, including directions about arrival, wearing a mask during the session, and getting set up for contactless payment beforehand.

Do you have special needs I should prepare for:

_____

Do you have any questions or concerns:

_____

If out-call, ask for directions, parking, or special instructions:

_____

Packet Checklist

- Health Information
- Health Status Report
- Billing Information
- Directions/map

Date sent _____

Additional Notes

_____

_____

_____

_____